CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

CHAPTER II
TABLE OF CONTENTS

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PROVIDER PARTICIPATION REQUIREMENTS AND CONDITIONS

PARTICIPATING PERSONAL/RESPITE CARE PROVIDER

A participating personal/respite care provider is an institution, facility, agency, person, partnership, corporation, or association that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and has a current, signed participation agreement with DMAS. Personal care and respite care are two services offered through Home and Community-Based Care Waivers. These services differ only in the reason that the service is rendered. The duties and responsibilities for the provider are the same for both services. The term personal/respite care is used throughout this manual wherever procedures and policies are alike for both services. A provider may, however, choose to offer only one of the two services.

Personal/respite care agencies provide services designed to prevent or reduce inappropriate institutional care by providing eligible individuals with personal/respite care aides who perform basic health-related services. This chapter specifies the requirements for approval to participate as a Medicaid provider of personal/respite care. Any provider contracting with Medicaid to provide services agrees as part of the provider participation agreement to adhere to all the policies and procedures in this provider manual.

REQUESTS FOR PARTICIPATION

Requests for applications for personal/respite care provider participation must be addressed to:

Provider Certification Analyst
Community-Based Care
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Requests will be screened to determine whether the applicant meets the basic requirements for participation (i.e., prior experience in the delivery of health-care-related service).

An application for provider status and information regarding provider participation requirements and standards will be mailed to any interested party who requests information/application to become a Medicaid-approved provider and who meets the basic requirements for participation. Upon receipt of a completed application, a DMAS Utilization Review Analyst will be assigned to conduct an on-site visit with the provider.

During this visit, the analyst will meet with the agency's staff and review the provider participation requirements and standards and obtain required personnel verification and

documentation from the provider. Upon DMAS receipt, review, and determination that the provider meets all the requirements for Medicaid provider participation, DMAS will send the provider two contracts for review and signature. The provider signs both and returns them to DMAS for validation; DMAS mails a validated copy to the provider.

GENERAL REQUIREMENTS

All providers approved for participation in the Medical Assistance Program must perform the following activities as well as any other specified by DMAS:

- Immediately notify DMAS, in writing, of any change in the information which the provider previously submitted to DMAS. This includes any change in provider status (location, mailing and payment address, administrative and nursing staff, etc.) as well as any change in a recipient's condition or level of service delivery as outlined in the policies in this manual.
- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed.
- Assure the recipient's freedom to reject medical care and treatment.
- Accept referrals for services only when staff is available to initiate services.
- Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, creed, age, or national origin.
- Provide services and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973 requiring that all necessary accommodations be made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities, and disabilities of coordination (refer to the section of this chapter titled "Requirements of Section 504 of the Rehabilitation Act").
- Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.
- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

- Accept Medicaid payment from the first day of eligibility.

- Accept as payment in full the amount established by the Department of Medical Assistance Services. 42 CFR, Section 447.15, provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the State. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered.

  Example: If a third party payer reimburses $5 out of an $8 charge, and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3 difference from Medicaid, the recipient, a spouse, or a responsible relative.

- Use Program-designated billing forms for submission of charges.

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Such records shall be maintained in a designated business office from which all personal care provider agency business is conducted.

- Such records must be retained for a period of not less than five years from the last date of service or as provided by applicable State laws, whichever period is longer, except that, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. Records of minors must be kept for at least five (5) years after such minor has reached the age of 18 years.

- Policies regarding the retention of records shall apply even if the agency discontinues operation. DMAS must be notified in writing of the storage, location, and procedures for obtaining records for review should the need arise. The location, agent, or trustee should be within the Commonwealth of Virginia.

- Furnish to authorized State and federal personnel, in the form and manner requested, access to records and facilities.

- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid.

- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. The State Agency shall not disclose medical information to the public.

- Employ and supervise professionally trained staff meeting the requirements stated in this chapter.

- Assure that no processing of bankruptcy or financial insolvency has been adjudicated or is pending in State or Federal Court and agree to inform DMAS of any action instituted with respect to financial solvency.

Advance Directives

At the time of their admission to services, all personal/respite care providers participating in the Medicare and Medicaid programs must provide adult recipients with written information regarding an individual's right to make medical care decisions as outlined in this section. This includes the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law and relating to the provision of such care when the individual is incapacitated. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive. Further, the law does not require individuals to execute an advance directive.

Under the law, personal/respite care providers must:

- Provide all adult individuals with written information about their rights under State law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives as well as the provider's written policies respecting the implementation of such rights;

- Inform recipients about the provider's policy on implementing advance directives;

- Document in the recipient's medical record whether he or she has signed an advance directive;

- Not discriminate against an individual based on whether he or she has executed an advance directive; and

- Provide staff and community education on advance directives.

PROVIDER PARTICIPATION STANDARDS

In addition to the above, to be enrolled as a Medicaid personal/respite care provider and maintain provider status, an agency must meet the following special participation conditions:

Staffing Requirements

1. Registered Nurse Requirements

The provider agency must employ (or subcontract with) and **directly supervise** a registered nurse who will provide ongoing supervision of all personal/respite care aides. The nurse must be currently licensed to practice in the Commonwealth of Virginia and have at least two (2) years of related clinical nursing experience. (Clinical experience may include work in an acute care hospital, public health clinic, home health agency, or nursing facility.) Documentation of both license and clinical experience must be maintained in the Provider Agency's personnel file for review by DMAS staff. There must also be documentation of positive work history as evidenced by at least two reference checks recorded in the nurse's personnel file.

The nurse must provide supervision of personal/respite care aides. The nurse must also provide quarterly in-service training, totaling a minimum of 12 hours within a calendar year. This in-service instruction may be provided by another qualified provider of such training, but the provider agency must ensure that in-service training is appropriate in content and is attended by all staff providing personal care. The nurse supervisor must offer in-service training (to include Medicaid requirements and policies and overall aide responsibilities) to all personal/respite care aides prior to their assignment to a Medicaid recipient and must document the offer in the aide's personnel file.

The RN supervisor must make an initial assessment visit prior to the start of care for any new patient admitted to personal/respite care. The RN supervisor is responsible for introducing each regularly assigned aide to the assigned recipient and orienting the aide to the recipient's Plan of Care on or prior to the aide's start of care for that recipient. The RN supervisor should closely monitor every situation when a new aide is assigned to a recipient so that any difficulties or questions are dealt with promptly.

The workload standard for the nurse supervisor can be expressed as either a nurse to aide or nurse to recipient ratio. The ratio of registered nurse supervisor to all aides supervised should be one full-time nurse supervisor to 40 aides. The ratio of registered nurse supervisor to all recipients supervised should be one full-time nurse supervisor to 35 recipients. This workload

standard is intended to be a guideline to insure quality supervision of personal/respite care recipients. In those instances where this ratio is exceeded, the DMAS utilization review analyst will evaluate the agency's existing ratio in light of observed quality of care and other impacting variables to determine if corrective action is warranted.

The registered nurse shall make supervisory visits as often as needed to ensure both quality and appropriateness of services. **A minimum frequency of these visits is every 30 days, not monthly.** The aide must be present during the nurse supervisor's visit at least every other visit. If the recipient is hospitalized on the day the 30-day RN supervisory visit is due, the RN visit is due by the third calendar day after the resumption of personal care services following hospitalization. For example, an RN supervisory visit was made on January 1 with the next visit due no later than January 31. The recipient is hospitalized from January 27 through February 5, and services resume February 6. The RN supervisory visit for the 30-day period (January 1 through January 31) had not occurred prior to the recipient's hospitalization. Therefore, an RN supervisory visit is due on or before February 9.

When respite care services are not received on a regular basis, but are episodic in nature (e.g., respite care is offered for one full week during a six-month period), the nurse supervisor is not required to conduct a supervisory visit every 30 days. Instead, the nurse supervisor must conduct the initial visit with the respite care aide immediately preceding the start of care and make a second home visit within the respite care period. If the respite is for a very short period of time (i.e., a weekend) a telephone call to the aide during the period of respite will suffice for the second visit. This telephone conversation must be clearly documented in the recipient's record. If the recipient is already receiving personal care services, and he or she is going to continue during the respite care period, the RN supervisor does not have to make a second visit during the respite care period regardless of the length of the period.

When respite care is authorized for an episodic period and the nurse supervisor is made aware of a need to extend the period of care, the nurse supervisor must contact the DMAS utilization review analyst to request approval for an extension of respite care. If an approval is given, DMAS will initiate a letter documenting the request for extension and the period of time for which the extension is granted.

In all cases, the nurse must be available to the aide for conference pertaining to individuals being served by the aide. Ongoing assessment of the aide's performance by the registered nurse is also expected to ensure the health, safety, and welfare of the recipient.

The RN providing supervision to aides must be available to the aides by telephone at all times that an aide is providing services to a recipient. An agency may contract with an RN to provide this service or find other means to meet this requirement since the agency **cannot** be without an RN. Any lapse in RN coverage must be reported immediately to the DMAS Community-Based Care Section.

2. Personal/Respite Care Aide Requirements

Each aide hired by the provider agency must be evaluated by the provider agency to ensure compliance with minimum qualifications as required by DMAS. Basic qualifications for personal/respite care aides include:

- Physical ability to do the work
- Ability to read and write
- Completion of a training curriculum consistent with DMAS requirements. Prior to assigning an aide to a recipient, the provider agency must obtain documentation that the aide has satisfactorily completed a training program consistent with DMAS requirements. DMAS requirements may be met in one of three ways:

  a. Registration as a Certified Nurse Aide: The Virginia Board of Nursing maintains a registry for Certified Nurse Aides. Each aide who is registered with the Board of Nursing will have a certificate of registration which contains a registration number and an expiration date. Any aide who has such a certificate meets the DMAS standard for participation as a personal/respite care aide. The provider RN should document the Certified Nurse Aide registry number and expiration date (the current date must be maintained in the file) in the aide's personnel file. DMAS does not require a Board of Nursing Certified Nurse Aide to perform personal/respite care services; it is merely one type of certification levels which meet DMAS requirements.

  b. Graduation from an Approved Educational Curriculum: The Board of Nursing has an approved list of educational curricula offered by educational institutions throughout the Commonwealth of Virginia which offer certificates qualifying the student as a Nursing Assistant, Geriatric Assistant or Home Health Aide. If an aide has successfully completed one of these courses approved by the Board of Nursing, the provider agency must obtain a copy of the applicant's certificate, assure that it is from an institution accredited by the Board of Nursing and maintain this documentation in the aide's personnel file for review by the DMAS staff.

Nursing Assistant training is also provided by numerous hospitals, nursing facilities, and educational institutions which are not approved by the Board of Nursing (e.g., out-of-state curricula). To assure that the training content for a Nursing Assistant Program not approved by the Board of Nursing meets the minimum acceptable requirements, the agency must contact the DMAS Utilization Review Analyst assigned to the provider agency and discuss the details of the training received, dates and hours of instruction received, and outline of the course content. The DMAS utilization review analyst will make a determination based on this information and send the provider written confirmation that the course meets DMAS requirements. This must be included in the agency's personnel files.

c. Provider-Offered Training: In lieu of participating in a course offered at an educational institution, training may be given by the registered nurse in the provider agency. The content of the training must be consistent with the basic course outline found in Appendix B, and prior approval must be given by the Department of Medical Assistance Services.

Regardless of the method of training received, documentation must be present indicating the training has been received prior to assigning an aide to a recipient. Based on continuing evaluations of the aide's performance and the recipient's individual needs, the nurse supervisor shall identify any significant gaps in the aide's ability to function competently and shall provide the necessary training. In addition to any in-service training provided to address identified needs of specific aides, the nurse supervisor is expected to develop and implement or otherwise ensure that quarterly in-service training appropriate to in-home care needs is provided at a minimum of 12 hours per calendar year for all personal/respite care aides.

The provider agency should verify information on the application form prior to hiring a personal care/respite aide. It is important that the minimum qualifications be met by each aide hired to ensure the health and safety of recipients. These qualifications must be documented and maintained in the provider personnel files for review by DMAS staff.

- Satisfactory Work Record Verified Through at Least Two References Obtained Prior to Employment - References must be employment references from the applicant's supervisor, unless the individual has never worked, in which case the references must be from individuals not related to the applicant. Documentation of the date of the reference check, the individual contacted and his or her relationship to the aide (friend, co-worker, supervisor), and the content of the reference must be maintained in the employee's record.

- Not a member of a recipient's family (Family is defined as parents, spouse, children, siblings, grandparents, and grandchildren.)

- A personal care aide who has legal guardianship or the committee for a personal care recipient may not be the provider of Medicaid-funded personal care services for the individual.

- A non-family live-in caregiver may be the provider of Medicaid-funded personal care services for any competent recipient. In these situations, the registered nurse supervisor must have contact with the recipient monthly when the live-in caregiver is not present.

3. Licensed Practical Nurse Requirements

Through the respite care program, the provider may be reimbursed for the services of a licensed practical nurse currently licensed to practice in the Commonwealth as long as the agency can document circumstances which require the provision of services by a licensed practical nurse. DMAS will reimburse for licensed practical nursing respite care to only those recipients who require the skilled level of care and who have no other support system other than the primary caregiver, who is the recipient of respite care.

The circumstances which warrant provision of respite care by a licensed practical nurse are:

- The individual receiving care has a need for routine skilled care which cannot be provided by unlicensed personnel (i.e., patients on a ventilator, patients requiring nasogastric or gastrostomy feedings, etc.).

- No other individual in the individual's support system is able to provide the skilled component of the individual's care during the caregiver's absence.

- The individual is unable to receive skilled nursing visits from any other source which could provide the skilled care usually given by the caregiver.

The provider must verify a satisfactory work record verified through at least two references obtained prior to employment. References must be employment references from the applicant's supervisor, unless the individual has never worked, in which case the references must be from individuals not related to the applicant. Documentation of the date of reference check, the individual contacted and the relationship to the aide (friend, co-worker, supervisor), and the content of the reference must be maintained in the employee's record.

Areas of Service

The provider applicant notes on the application what localities (cities and counties) the provider wishes to serve. The provider may be approved without special authorization to serve individuals who reside in the base locality in which the provider agency office is located and in any localities contiguous to that locality. If the provider wishes to serve areas which are not contiguous to the base locality in which the provider agency is located, the provider must be able to show that the area is under-served (i.e., no providers are located in that area or insufficient providers are located to serve the need in that area) or that the provider can meet a unique need in that area which other providers in the area are unable to meet. The provider must be able to adequately staff and supervise staff in that non-contiguous locality from the provider agency office. Written approval from the DMAS analyst must be obtained to expand into a locality which is not contiguous to the provider agency's locality prior to serving anyone in that area.

If the provider is unable to demonstrate need or that adequate staffing or supervision can be maintained from the provider agency into a non-contiguous locality, the provider has the option to open a separate provider agency in that non-contiguous locality. The provider would submit a provider application for this separate office which, upon approval, would be issued a separate provider identification number and would be expected to maintain all files related to recipients served by the office and to bill for those recipients from the office.

Agencies located in Richmond City will be considered to be based in Richmond City, Chesterfield and Henrico Counties, so all counties contiguous to these will be within the Richmond City agency's service area.

A differential rate is established for providers operating from the Northern Virginia localities (defined in Chapter VI) to reflect the higher cost of operating in these localities (both higher capital and wage costs). Therefore, providers in these localities are restricted from providing services to recipients residing in non-Northern Virginia localities, except in individual cases where no other provider is able to serve the needs of the recipient.

Inability to Provide Services and Substitution of Aides

The provider is responsible for providing reliable, continuous care to any Medicaid personal/respite care recipient for the number of hours and days outlined on the Plan of Care. DMAS considers a high degree of continuity to be no more than three days missed coverage in a six-month period. Any time the provider is unable to furnish an aide to perform services authorized in the Plan of Care, the recipient or recipient's family must be notified immediately and documentation of the contact recorded in the recipient's file. When the permanent aide is absent, the provider must attempt to provide a substitute aide. An inability to provide service can be considered a serious threat to the safety and health of a recipient who does not have a support system available to provide back-up support.

The provider should explore with the recipient, prior to the start of services, his or her ability to go without service in the event the provider cannot send a substitute aide. Back-up support can be provided by lifeline service or informal network of friends/neighbors who can be called on as needed as long as this assures the recipient's needs are met.

If a provider agency cannot supply an aide to provide authorized services, the agency can either obtain a substitute aide from another agency, if the lapse in coverage is to be less than two weeks in duration, or can transfer the recipient to another agency. If no other provider agency is available which can supply an aide, the provider agency should terminate the services according to policies stated in Chapter V of this manual. The provider agency must notify the recipient or family to contact the local health department to request a Nursing Home Pre-Admission Screening if nursing facility placement is desired.

During temporary, short-term lapses in coverage (not to exceed two weeks in duration), a substitute aide may be secured from another provider agency or other home care agency. The following procedure applies:

- The agency having recipient responsibility must provide the registered nurse supervision for the substitute aide.
- The agency providing the substitute aide must send to the agency having recipient care responsibility a copy of the aide's daily records signed by the recipient and the substitute aide. All documentation of services rendered by the substitute aide must be in the recipient's record. The documentation of the substitute aide's qualifications must also be obtained and recorded in the agency having recipient care responsibility.
- The provider agency having case responsibility will bill DMAS for services rendered by the substitute aide. (The two agencies involved are responsible for working out the financial arrangement of paying the substitute aide.)

Substitute aides obtained from other agencies should be used only in cases where no other arrangements can be made for personal care services coverage and should be used on a temporary basis. If a substitute aide is needed for more than two weeks, the case must be transferred to another provider agency that has the aide capability to serve the recipient(s).

If a provider agency secures a substitute aide, it is the responsibility of the provider agency having recipient care responsibility to ensure that all DMAS requirements continue to be met, including documentation of the services rendered by the substitute aide and documentation that the substitute aide's qualifications meet DMAS requirements.

Demonstrated Prior Successful Community-Based Health Care Delivery

DMAS requires that the provider applicant (i.e., administrative staff who will be responsible for program operation) be able to demonstrate a history of prior successful health care delivery in a

community-based setting in order to attempt to ensure consistent, stable delivery of quality home-care services to Medicaid recipients. Prior successful health care is defined as consistent provision of health care services in a community setting for a period of at least 12 months prior to application for Medicaid provider status. This can be assessed by a review of certification by another state service entity, review of agency business files, review of professional references from service referral or other service delivery sources, etc.

Business Office

The provider must operate from a business office which is staffed and provides accessible staff space, files, business telephones and an address for receipt of mail and forms.

Change of Ownership

When ownership of the provider agency changes, the DMAS analyst assigned to the agency must be notified within 15 calendar days. A new application with a notice of organizational structure, statements of financial solvency and service comparability, and full disclosure of all information required by this chapter relating to ownership and interest will be required.

PROVIDER IDENTIFICATION NUMBER

Upon receipt of the signed contracts, approval, and signature by DMAS, a provider identification number will be assigned. The provider will be sent a copy of the contract and the assigned provider identification number. **DMAS will not reimburse the provider for any services rendered prior to the assignment of this provider identification number and the receipt of this number in writing by the provider.** This number must be used on all billing invoices and correspondence submitted to DMAS.

REVIEW OF PROVIDER PARTICIPATION AND RENEWAL OF CONTRACTS

Providers are continually assessed to assure conformance with Medicaid participation standards and Program policies. The provider is assessed on its ability to render consistent, high-quality care to a population in need of nursing facility level of care. Information used by DMAS to make this assessment includes DMAS desk review of documentation submitted by the provider (personal care providers only) as well as on-site review of provider files and interviews with staff and with recipients on visits to recipients' homes and via responses to quality assurance survey letters. The DMAS assessment of the provider is based on a comprehensive evaluation of the provider's overall performance in relation to the following Program goals:

1. Recipients served by the provider meet the Program's target population:

a) Personal/respite care services through the Elderly and Disabled Waiver are targeted to individuals who meet nursing facility level of care criteria or pre-nursing facility criteria (criteria which describe persons who will meet nursing facility criteria in the near future but for the provision of community-based care) and are at risk of nursing facility placement (as outlined in criteria in Appendix D).

b) Services through the AIDS Waiver are targeted to individuals who meet nursing facility level of care or who, without the receipt of services under the waiver, will require the level of care provided in a hospital as outlined in Appendix D.

The agency has a responsibility to be aware of the criteria for these two programs and to, on an ongoing basis, evaluate recipients' appropriateness for services accordingly. The agency must terminate services, using the procedures outlined in Chapter V, for any recipient whose condition does not meet target population criteria.

2. Services being rendered meet the recipient's identified needs and are within the Program's guidelines. The agency is responsible for continuously assessing the recipient's needs through visits made by the RN supervisor and communication between the aide and the RN Supervisor and other agency staff. The Plan of Care must be revised in accordance with any substantial change in the recipient's condition, and the recipient's record must contain documentation of any such change. This also includes the agency's responsibility to identify and make referrals for any other services which the recipient requires to remain in the home setting (e.g., medical equipment through DME, skilled nursing visits, etc.).

3. The agency documentation must support all services billed to DMAS.

4. Services are of a quality that meets the health and safety needs and the rights of the individual. Quality of care is best assured through an emphasis on communication and respect between the recipient, the aide and the RN Supervisor who is responsible for the oversight of the care rendered. The quality of care is best assessed through communication with recipients and aides. Some of the elements included in quality of care are:

- Consistency of Care: The degree to which the recipient receives services from an aide familiar with the recipient's needs, home environment and Plan of Care, measured by the number of permanent aides assigned (aide regularly assigned, not a substitute) to the recipient in a six-month period and/or the recipient's reported satisfaction with the aide's familiarity with the recipient's needs and ability to respond to the needs of the recipient.

Although, ideal consistency is obtained through the assignment of one aide who continues to render care to that recipient, there are numerous occasions which will necessitate a substitute or reassignment. The agency should strive to address consistency of care with aide staff and discuss with recipients ways to minimize the effects of staff turnover.

- Continuity of Care: The degree to which the recipient receives services continuously according to the Plan of Care, measured by the number of days of authorized service not rendered by the provider due to the provider's inability to staff rather than due to the recipient's or recipient's family's request. DMAS considers excellent continuity of care as three or less days missed during a six-month period. More than three days missed due to the provider's inability to provide staff would not indicate poor continuity, but may correlate to a decrease in the overall quality of care.

- Adherence to the Plan of Care: It is the provider's responsibility to provide services according to the amount and type needed and to maintain a current Plan of Care. A Plan of Care that calls for services to be rendered on a seven-day-a-week basis must be staffed on that basis unless the provider has discussed this with the recipient and family, and they are able to provide the coverage in the absence of the regularly assigned aide. This must be documented in the recipient's file. Holidays are no exception to this criteria. Any recipient who does not have a support system available to provide care on the provider's regularly scheduled holidays must either be provided service on the holiday or the provider must not accept the case upon referral.

- Health and Safety Needs of the Recipient: The provider must identify any health and safety issues and communicate those to appropriate family members, other agencies, etc., as well as follow-up to see that these issues get resolved. This includes the provider's responsibility to identify any special needs of the recipient and act to refer the recipient to service providers to meet those needs.

DMAS will review the provider's performance in all the Program goal areas to determine that provider's ability to achieve high quality of care and conform to DMAS policies. The analyst is responsible for providing feedback to the provider regarding those areas which may need improvement. All providers receive on-site reviews twice during their first year of Medicaid provider participation. The first review is conducted within 60 days of the start of care with the agency's first recipient, and the second is six months from the first on-site review. Reviews are conducted annually thereafter.

During these on-site reviews, the analyst will review recipient files and conduct home visits to assess the quality of care and continued appropriateness of personal/respite care.

DMAS will communicate in writing with all providers following the on-site review to identify strengths and any areas in which improvement is needed.

Provider Participation Agreements are issued initially for one year and are then renewed by DMAS every two years. DMAS utilization review analysts are assigned to each provider agency for purposes of the review of provider compliance with participation standards and annual recipient utilization review.

DOCUMENTATION REQUIRED - RECIPIENT RECORD

The provider agency shall maintain a record for each recipient. **These records must be separated from those of other services, such as companion services or home health.** If a recipient receives personal care and respite care services, one record may be maintained but separate sections should be reserved for the documentation of the two services. These records shall be reviewed periodically by DMAS staff. At a minimum, these records shall contain:

- Pre-Admission Screening Assessment Instrument (DMAS-95 or DMAS-113A for AIDS Waiver individuals); the Nursing Home Pre-Admission Screening Authorization signed by all members of the Screening Committee (DMAS-96); the Screening Committee Plan of Care (DMAS-97 or DMAS-113B for AIDS Waiver individuals or DMAS-300 for respite care services); all provider agency Plans of Care (DMAS-97A), and all DMAS-122's. Appendix C contains copies of these forms.

- All DMAS utilization review forms and Plans of Care.

- The initial assessment by the RN supervisory nurse completed prior to or on the date services are initiated and filed in the agency record within five working days from the date of the visit. (See Chapter IV for the content of the initial assessment.) The example standardized form may be used to document the initial visit. (See Appendix C.)

- All RN supervisory notes pertaining to the required 30-day visits must be on file within five working days of the date of the visit. (See Chapter IV for the content of the initial assessment.)

- All RN/Coordinator/staffing person notes regarding contacts made between the RN's 30-day visits. This includes documentation of contacts with recipients or support system when services can't be delivered. Other contacts may be with family, physician, DMAS or other professionals. All notes must be recorded in the recipient's file within five working days of the contact. White-out must not be used to make corrections to the file.

- A copy of all Recipient Progress Reports submitted to DMAS.

- All correspondence between the agency and the recipient or DMAS.
- Personal/Respite Care Aide Record (DMAS-90) of services rendered and the recipient's responses.. See Chapter IV for content of the Aide Record.

RECIPIENT RIGHTS/RESPONSIBILITIES

The provider must have a written statement of recipient rights which clearly states the responsibilities of both the provider agency and the recipient in the provision of care. This statement of recipient rights must be signed by the recipient and the provider representative at the time services are initiated. This statement must be maintained in the recipient's file and a copy must be given to the recipient. The recipient rights statement must include the following:

- The provider's responsibility to notify the recipient in writing of any action taken which affects the recipient's services.
- The provider's responsibility to render services according to acceptable standards of care.
- The provider's procedures for patient pay collection.
- The recipient's obligation for patient pay, if applicable.
- The provider's responsibility to make a good faith effort to provide care according to the scheduled Plan of Care and to notify the recipient when unable to provide care.
- The provider must inform the recipient of his or her responsibility to have some planned back-up for times when the provider is unable to secure coverage and to identify which staff the recipient should contact regarding schedule changes.
- The provider's responsibility to treat the recipient with respect, to respond to any questions or concerns about the care rendered, and to routinely check with the recipient about his or her satisfaction with the services being rendered.
- The recipient's responsibility to notify the appropriate provider agency staff whenever the recipient's schedule changes or assigned staff fail to appear for work.
- The recipient's responsibility to treat employees of the agency with respect and to communicate problems immediately to the appropriate provider staff.

The Recipient's Rights/Responsibilities Statement must include the following notification of the appropriate source for complaints:

"The DMAS (Medicaid) pays (provider name) to provide (type of service) to you. If you have a problem with these services you should contact (RN) at (agency phone).

If the staff at the agency is unable or unwilling to help you resolve the problem, you may contact the DMAS in writing or by phone at:

DMAS - Community Based Care
Name of Analyst Assigned to Your Agency
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
1-800-421-7376"

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 provides that no handicapped individual shall, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provision for handicapped individuals in his or her program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. By signing the check, the provider indicates compliance with Section 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

PROVIDER SANCTIONS (Adverse Actions)

Sanctions are any adverse action taken by DMAS based on documented non-compliance by the provider. There are three categories of sanctions imposed by the Department of Medical Assistance Services: Reimbursement Sanctions, Caseload Sanctions and Contract Sanctions. The following describes these sanctions and the manner in which they are applied:

1. Reimbursement Sanctions - A reimbursement sanction is any disallowed claim for Medicaid services due to the service's being rendered in a manner which is not in accordance with DMAS policies and procedures. Reimbursement sanctions are of two types: recipient-specific and provider-specific. The distinctions are important in relation to how the sanction is applied.

    a. Recipient-Specific Sanction: This sanction is a disallowance of payment for a claim for which the DMAS analyst is either unable to verify that the

service was rendered or the service was rendered in a manner which is not authorized by the Plan of Care or according to DMAS policies. The following are examples of situations that will give rise to recipient-specific reimbursement sanctions:

- No signatures on the log sheet;
- Missing documentation for special services as required in Chapter II, page 15, "Documentation Required."
- No way to determine the number of hours that service was rendered;
- Missing log sheets and/or missing RN notes;
- The Plan of Care authorizes 25 hours per week and the recipient received 30;
- The Plan of Care calls for five-day-per-week service of three hours per day, and the provider rendered three days of five-hour service without documentation of the need and circumstances.

b. Provider-Specific Reimbursement Sanction: The disallowance of claims for more than one recipient based on the provider's failure to adhere to provider participation standards (e.g., staff qualification requirements and RN supervisory visit requirements) which directly impact service delivery to recipients. The following is an example of a situation that will give rise to provider-specific reimbursement sanctions:

- The provider fails to employ a RN to provide supervisory visits during one month affecting five recipients who are not seen by a RN within the 30-day-period required by DMAS policy. Claims for personal care for that month will be disallowed for all five recipients.
- A review of provider personnel files shows that three of the aides employed by the provider to render personal care services do not meet DMAS personal care aide training requirements. Claims for days of service for any recipient for whom services were rendered by these aides will be disallowed.

Provider non-compliance in situations other than these examples will be cited as a deficiency in the post-review letter to the provider and a warning will be given that DMAS will impose a sanction if the non-compliance re-occurs or continues. For example, upon review, the analyst finds that the Plan of Care developed by the provider exceeded the needs of the recipient (the care plan allowed five hours per day for a recipient who only needs two hours per day). The analyst discusses this finding with the provider and in the post-review letter states why this determination

was made and provides instructions to the provider for correction of the Plan of Care. A reimbursement sanction will be imposed if the analyst had previously documented such non-compliance.

If the analyst documents that the provider has established a pattern of non-compliance (e.g., excessive care plans), and the analyst warns the provider in writing that repeated failure to adhere to policies may result in a sanction, the analyst will impose a recipient-specific reimbursement sanction and may require the provider to have all plans of care pre-approved by the analyst.

2. Caseload Sanctions - These sanctions are applied to protect the health and safety of recipients when a provider is not in compliance with provider participation standards and therefore is not able to provide adequate Community-Based Care (CBC) coverage. Caseload sanctions include:

   a) A freeze on all new admissions, and

   b) The transfer of recipients to other CBC providers or nursing facilities.

   A request for a corrective action plan to be reviewed and approved by DMAS will be initiated whenever a caseload sanction is imposed.

3. Contract Sanctions - These sanctions are applied when a provider demonstrates an inability to comply with either provider participation standards or Program policies and therefore presents a risk to the quality of care of CBC recipients or an immediate risk to their health and safety which cannot be corrected. Contract sanctions include:

   a) Time-Limited Contract - The provider is attempting to correct the non-compliance but has not made sufficient progress to warrant a full two-year contract. A contract may be issued for a period not less than one month and not greater than one year.

   b) Contract Not Renewed - The provider's contract may be due for renewal, and progress has not been sufficient to allow renewal of the contract on even a limited basis.

   c) Contract Termination - The provider has been unable to correct the non-compliance and presents an immediate risk to recipients of CBC services.

A corrective action request must be initiated whenever a time-limited contract sanction is imposed.

PROVIDER CORRECTIVE ACTION

A provider's non-compliance with DMAS policies and procedures may result in a written request from DMAS for a corrective action plan which details the steps the provider

will take and the length of time required to achieve full compliance with deficiencies which have been cited. The decision to request corrective action will be based on the type of non-compliance and its affect on the overall quality of care, whether a pattern of non-compliance exists, whether the non-compliance presents a threat to the health and safety of recipients, and the circumstances that may have created the non-compliance. For example, a provider's failure to follow policies due to a sudden staff turnover may not represent a pattern of non-compliance or present an immediate threat to the health and safety of recipients, and thus a corrective action may not be necessary.

DMAS will identify and document non-compliance issues to the provider and offer technical assistance to correct the non-compliance. A request for corrective action will be issued when the non-compliance continues after having been addressed with the provider by DMAS (except in those instances where the risk of immediate danger to recipients requires immediate improvement). A corrective action may include a caseload or contract sanction.

The provider shall respond with a written corrective action plan within 10 working days of the DMAS request. DMAS will review the plan and respond to the provider within 15 days of receipt of the plan regarding the acceptability of the plan. DMAS will closely monitor the provider's progress and provide a written corrective action progress report at the end of the first quarter in which the plan takes place. At the end of a six-month period, a provider may be removed from corrective action status if DMAS finds that correction has been achieved. Failure either to respond to a request for corrective action or to adhere to the approved corrective action plan may result in contract revocation according to the termination procedures described later in this chapter.

TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate his or her participation in Medicaid at any time. Written notification of voluntary termination should be made to the following address 60 days prior to the effective date:

Manager, Community-Based Care
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS may administratively terminate a provider from participation upon 60 days' written notification prior to the effective date. DMAS may also cancel a contract immediately or may give notification in the event of a breach of the contract by the provider as specified in Article VII of the contract. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

RECONSIDERATION OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action which includes termination or suspension of the provider agreement.

The reconsideration process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days from the date of the notice to submit information for written reconsideration, and will have 15 days to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (Code of Virginia, Title 9, Chapter 1.1:1, Section 9-6.14:1 et seq.) and the State Plan for Medical Assistance provided for in Title 32.1, Chapter 10, Section 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice in the Commonwealth of Virginia.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

The Code of Virginia, Chapter 10, Department of Medical Assistance Services, Section 32.1-325(c), mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify the Program of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of State law.